

IN THE UNITED STATES DISTRICT COURT  
FOR THE EASTERN DISTRICT OF ARKANSAS  
LITTLE ROCK DIVISION

JEWELLEAN MOORE,  
PLAINTIFF

VS.

CRESENT MEDICAL CENTER

DR. EMANUEL RAFAEL,  
DEFENDANTS.

**FILED**  
U.S. DISTRICT COURT  
EASTERN DISTRICT OF ARKANSAS  
NOV 17 2016  
JAMES W. MCCORMACK, CLERK  
By: [Signature] DEP CLERK

*4:16 CV 845-BRW*

COMPLAINT FOR MEDICAL MALPRACTICE

WITH JURY DEMAND

This case assigned to District Judge Wilson  
and to Magistrate Judge Harris

PRELIMINARY STATEMENT:

Comes now the Plaintiff, Jewellean Moore, Brings this Action pertaining to Medical  
Malpractice and Negligence against Cresent Medical Center and Doctor Emanuel Rafael.

JURISDICTION:

Plaintiff is a Citizen of Little Rock Arkansas, the Defendants are Citizens who Work/Resides  
in the Lancaster, Texas area. This Court have Jurisdiction, pursuant to 28 U.S.C. 1332,

PARTIES:

- 1) Plaintiff- Jewellean Moore, 6200 Colonel Glenn Rd,#219, Little Rock, AR.72204
- 2). Defendant-Crescent Medical Center, 2600 W. Pleasant Run Rd., Lancaster,TX.75146;
- 3). Defendant-Doctor Emanuel Rafael, 2600 W. Pleasant Run Rd.,Lancaster, TX. 75146.

STATEMENT OF CLAIM:

A). On May 6,2016, while Visiting the Dallas area, Plaintiff, hereinafter "Moore", Checked in the Cresent Medical Center for Emergency Medical Treatment. where Moore had sudden extreme violent Headaches, Vomiting, disorientation, and sensitivy to light. Dr. Emamuel-Rafael, was the Attending Emergency Physician. because of Moore's inability to Speak coherently, Moore's Partner, Arthur Carson , briefed Dr. Rafael of Moore's Medical dilemma. the Defendants failed to apply any standard of Medical Care toward Moore, by gross negligently discharging Moore, despite Her inability to Walk on Her own, Vomiting and overall worsening condition. see attached, (Exhibit #1 "excerpts from Moore's Medical charts" )

B).The Defendants failed to perform any Neurological tests, or blood evaluation, and ignored Moore's plea for help. the Defendants failed to diagnose and treat what was Severe Sepsis, that had altered Moore's speech, and diminished Her ability to identify People.

The Defendants prescribed Clonidine for high blood pressure and Discharged Moore.

C). Overnight for several hours Moore constantly Vomited and suffered excruciating Head-aches, and lost Her ability to Walk. after Arthur Carson witnessed the overall deterioration the Morning of May 7,2016, He made arrangements to transport Moore to Baylor-White & Scott Hospital Emergency Room, where Moore would remain for five days for severe Sepsis.

D).As a direct and proximate result of Defendants indifference to Moore suffering, there was a breach of applicable standard of Medical care, that caused Moore conscious pain, and suffering, Memory problems and other cognitive damages, and subsequent Hospitalization from May 7-11, 2016, in Baylor/Scott & White in Dallas, Texas. see

(Plaintiff's Exhibit NO.2 "Excerpts from Baylor-Scott & White".)

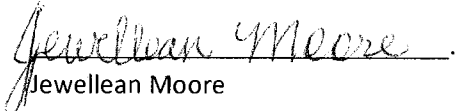
The Defendants premature discharge were done so despite Moore's Blood pressure was never stabilized and remained dangerously high, (214/97 BP reading). Defendants Negligence in treating Moore's Life Threatening infection allowed it to Worsen and cause havoc.

E). At All relevant times, Dr Rafeal, was Employed by Cresent Medical Center, and were acting within the scope of His Employment.

PRAYERS:

WHEREFORE, PREMISES CONSIDERED, PLAINTIFF PRAY That Damages of One Million Dollars from Each Defendant to Plaintiff; Court Cost; all Else Relief this Court deem Equitable.

Respectfully Submitted

  
Jewellean Moore

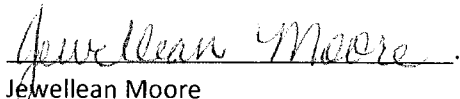
(972-897-0182)

6200 Colonel Glenn Rd #219

Little Rock AR 72204

I Jewelleam Moore, swear the foregoing statements are true and correct,pursuant to 28 U.S.C.

1746.

  
Jewellean Moore



**Patient Name:** MOORE, JEWELLEAN

**DOB:** 07/03/1955

**MR#:** 2020588 **ACCT#:** 10033694

**Admit Date:** 05/06/2016

**Headache.3 Entry Date:** 05/06/2016 15:01:53

---

## History of Present Illness

SEMBA TARISHA 05/06/2016 12:55

**Chief Complaint:** Headache

**DATE / TIME Seen by Provider:** 05/06/2016 12:52

**Is Patient Pregnant:** No

**Means of Arrival:** Automobile

**History Reported By:** Patient, Spouse

**Symptoms:**

Include: New Onset Headache, Nausea, Vomiting, disoriented, eye pain

**Onset Mode:** Sudden

**Onset:** Today

**Preceding Event:** Pt has not been taking her HTN medication

**Timing:** Constant

**Severity:** Moderate

**Progression:** Worsening

**Exacerbating Factors:** None Reported

**Relieving Factors:** None Reported

## Review of Systems

SEMBA TARISHA 05/06/2016 12:55

**ROS Otherwise Negative:** Complete Review Otherwise Negative

**Instructions:**

F60 presents to the ED accompanied by spouse c/o headache that began today. Historian reports the headache has worsened in the last hour, and pt became disoriented, and pt is now vomiting. Pt states her "eyes feel like they are going to burst open" and states she has not been taking her HTN medication.

**CONSTITUTIONAL / GENERAL:** Patient reports nausea, vomiting, and denies fever, fatigue and changes in appetite or activity.

**EENT:** Patient reports eye pain and denies visual changes, hearing loss, nasal stuffiness, sore throat, discharge or drainage.

**RESPIRATORY:** Patient denies any shortness of breath, difficulty breathing, wheezing or cough.

**CARDIAC:** Patient denies chest pain, palpitations, shortness of breath, difficulty breathing, and dyspnea with exertion.

**MUSCULOSKELETAL:** Patient denies problems with extremities, joints, muscles or tendons.

**INTEGUMENTARY:** Patient denies changes in skin, hair and nails.

**NEUROLOGICAL:** Patient reports headache, disoriented

**PSYCHOLOGICAL:** Patient denies depression, sadness, suicidal or homicidal thoughts.

**ENDOCRINE:** Patient denies fatigue, polydipsia, polyuria, changes in body or facial hair.

**HEME/LYMPH:** Patient denies unusual bruising, bleeding or swollen glands.

## Clinical Data:

**Pain Scale:** 10 - Worst Possible Pain 05/06/2016 12:38

**BMI:** 46.41 05/06/2016 12:32

**BSA:** 2.3 05/06/2016 12:32

**Blood Pressure:** 214/97 Lying Right Arm 05/06/2016 12:32



**CRESCENT**  
MEDICAL CENTER  
LANCASTER

**Patient Name:** MOORE, JEWELLEAN

**DOB:** 07/03/1955

**MR#:** 2020588 **ACCT#:** 10033694

**Admit Date:** 05/06/2016

**ED Discharge Instructions Entry Date:** 05/06/2016 15:01:55

---

### **Diagnosis and Instructions**

EMANUEL RAPHAEL EMERGENCY MEDICINE 05/06/2016 14:57

**Your Diagnosis Is:** Other headaches/htn

**Disposition:** Discharge to Home, Follow-Up with Primary Care

**Diagnosis Specific Education:** Diagnosis related handout given

**Activity:** Resume normal activity.

**Diet Order:** low salt

**Medications:** Prescriptions given clonidine must please follow nt wk with pcp

**Electronically Signed By:** RAPHAEL EMANUEL, MD, EMERGENCY MEDICINE 05/06/2016 15:01:55

**Baylor Scott & White Medical Center - White Rock**9440 Poppy Drive  
Dallas, TX 75218-3652**Patient:** MOORE, JEWELLEAN**MRN #:** 447638**Account #:** 3047830**DOB/Age/Sex:** 7/3/1955 / 61 years / Female**Attending Provider:** LINK MD,JEFFREY J**Admission Date:** 5/7/2016**Discharge Date:** 5/7/2016**Lab Medical Director(s):** Dr. Charles E. Mangum**Emergency/Urgent Care**

Document Type: ED Note-Physician  
 Document Date/Time: 5/7/2016 10:18 CDT  
 Document Status: Auth (Verified)  
 Performed By: Demir,Candas (5/7/2016 10:29 CDT)  
 Authenticated By: LINK MD,JEFFREY J (5/7/2016 17:09 CDT); Demir,Candas (5/7/2016 16:39 CDT); Demir,Candas (5/7/2016 16:05 CDT)

**HA - Headache\*****Patient:** MOORE, JEWELLEAN **MRN:** 447638 **FIN:** 3047830**Age:** 60 years **Sex:** Female **DOB:** 07/03/1955**Associated Diagnoses:** Hypertensive emergency; Altered mental status; Leukocytosis; Morbid obesity; Diabetes mellitus with hyperglycemia**Author:** Demir, Candas**Basic Information****Time seen:** Date & time 05/07/2016 10:18:00.**History source:** Patient.**Arrival mode:** Private vehicle.**History limitation:** None.**History of Present Illness**

The patient presents with headache. The onset was yesterday. The course/duration of symptoms is constant and worsening. Location: Right parietal generalized. Radiating pain: none. The character of symptoms is sharp and pressure. The degree at onset was moderate. The degree at maximum was severe. The degree at present is severe. There are exacerbating factors including light, exertion and standing. The relieving factor is none. Risk factors consist of diabetes mellitus and hypertension. Prior episodes: none. Therapy today: none. Preceding symptoms: none. Associated symptoms: photophobia, altered speech, altered level of consciousness, denies nausea, denies vomiting, denies dizziness, denies altered vision, denies fever, denies chills and denies syncope. The patient was in too much distress to give history. Per husband, the patient experienced elevated blood pressure yesterday, noted to be 96/239 with severe headache. She was taken to Crescent health care facility in Lancaster where she had her blood pressure taken down and was prescribed Clonidine but did not have her prescription filled. The husband states that after this treatment her symptoms actually worsened, where she had persistent elevated blood pressure with associated changes to her ability to speak, identify people and gait. The patient has not taken any blood pressure or diabetes medications for the past 2 days. The patient is noted to have experienced a minor stroke about 10 years ago, dissimilar in symptoms to today. The patient has glaucoma..

**Review of Systems****Constitutional symptoms:** No fever, no chills.**Respiratory symptoms:** No shortness of breath,**Cardiovascular symptoms:** No chest pain,**Neurologic symptoms:** Headache, No dizziness,**Additional review of systems information:** All other systems reviewed and otherwise negative.**Health Status****Allergies:**Allergic Reactions (All)

Severity Not Documented

Penicillins- No reactions were documented..

**Medications: (Selected)**PrescriptionsPrescribed

Lantus 100 units/mL subcutaneous solution: 10 Unit(s), Subcut, Daily, for 30 day, 1 vial, 2 Refill(s)

albuterol 90 mcg/inh inhalation powder: 2 puff, Inhalation Oral, Once Scheduled, 1 inhaler, 1 Refill(s)

azithromycin 250 mg oral tablet: 1 packet(s), Oral, Once Scheduled, as directed on package labeling, 6 tab, 0 Refill(s).

**Immunizations:** Up to date.

Exhibit # (2)

**BAYLOR UNIVERSITY MEDICAL CENTER**

PATIENT NAME: Moore, Jewellean  
 MRN / ACCOUNT #: 368719 / 61922134  
 DOB / AGE / SEX: 07/03/1955 / 61Y / F

ADMIT DATE: 05/07/2016 06:22 PM  
 DICTATION DATE/TIME:  
 PROVIDER: Westfall, Amanda

**ED PHYSICIAN NOTES**

## Physician Documentation

Baylor University Medical Center

Name: Jewellean Moore

Age: 60 yrs

Sex: Female

DOB: 07/03/1955

MRN: 00368719

Arrival Date: 05/07/2016

Time: 18:22

Account#: 61922134

Bed B22

Private MD:

ED Physician Westfall, Amanda

Diagnosis: Sepsis; Urinary Tract Infection (UTI); Acute Headache; Essential  
 hypertension ; Fever

## HPI:

05/07

18:58 This 60 yrs old Black Female presents to ER via EMS (Ground) with tc11  
 complaints of High Blood Sugar - 5/07 transfer BSWH WhiteRock.

19:49 Pt recently moved here from Arkansas. She has been out of her BP meds tc11  
 x 1 week due to Medicare not paying in a new state. Pt felt well but  
 noticed her BP elevated yesterday. She went to free standing urgent  
 care clinic to have meds filled. She was given Clonidine and BP came  
 down but pt developed HA while there. Husband reports that she also  
 felt dizzy, off balance, was not talking normally at the clinic but  
 was d/c home with Rx for Lisinopril/HCTZ and Amlodipine. She went  
 home with HA and vomiting all night. Husband reports that she was  
 still with HA, dizziness and "not talking right" this morning so they  
 went to Baylor of White Rock. She had temp 100.7, CT nl except for  
 prior lacunar infarcts, MR showed Chiari 1 malformation, CXR  
 cardiomegaly with vascular congestion, no pneumonia, glucose 532 but  
 nl CO2 and gap, CRP elevated 1.4, SED Rate elevated at 101 lactate  
 elevated 2.4, nl troponin, WBC elevated at 12 with nl bands, UA nl,  
 ABG nl. Pt had elevated BP and was started on cardene drip. She was  
 transferred to BUMC for further evaluation..

20:03 The patient has elevated blood pressure and discovered this at home. tc11  
 Onset: The symptoms/episode began/occurred yesterday. Modifying  
 factors: The symptoms are aggravated by discontinuation of meds.  
 Associated signs and symptoms: Pertinent positives: dizziness,  
 headache, lightheadedness, vomiting, AMS. Severity of symptoms: At  
 its worst the blood pressure was severe, in the emergency department  
 the blood pressure is improved, markedly, on Cardene drip. The  
 patient has not experienced similar symptoms in the past. After  
 initial evaluation, subsequent history was obtained from Husband. The

**Moore, Jewellean**

Enterprise Patient ID: 1295838

Medical Record #: 368719 / Account #: 61922134

ED Physician Notes



**BAYLOR UNIVERSITY MEDICAL CENTER**

PATIENT NAME: Moore, Jewellean  
 MRN / ACCOUNT #: 368719 / 61922134  
 DOB / AGE / SEX: 07/03/1955 / 61Y / F

ADMIT DATE: 05/07/2016 06:22 PM  
 DICTATION DATE/TIME:  
 PROVIDER: Westfall, Amanda

**ED PHYSICIAN NOTES**

20:00 Order name: Urine Microscopic, Automated; Complete Time: 20:42      dispat  
 05/07  
 20:39 Order name: Urine Microscopic; Complete Time: 20:42      dispat  
 05/07  
 23:31 Order name: POC Whole Blood Glucose      dispat  
 05/08  
 01:07 Order name: Lactate - Serum      jlb77  
 05/07  
 22:51 Order name: Chest 1 View XRAY Portable      aw21  
 05/07  
 18:44 Order name: Update allergies in Eclipsys and notify RN of any      cw37  
 discrepancies; Complete Time: 18:45  
 05/07  
 21:30 Order name: \S\SEVERE SEPSIS - Please activate (Notify Primary Nurse);      cw37  
 Complete Time: 00:16  
 05/07  
 23:51 Order name: Allscripts Orders for Review      dispat  
 05/07  
 18:48 Order name: Draw Blood Cultures; Complete Time: 21:19      cw37  
 05/07  
 18:54 Order name: Set Up - Adult LP (Lumbar Puncture) Tray; Complete Time:      tc11  
 19:03  
 05/07  
 19:20 Order name: Recollect Lavender Top: CLOTTED; Complete Time: 21:02      br18  
 05/07  
 20:01 Order name: Oxygen - Nasal Cannula; Complete Time: 20:16      lv14  
 05/07  
 21:30 Order name: If no IV access within 15 minutes, please notify      cw37  
 physician; Complete Time: 21:54  
 05/07  
 21:30 Order name: Monitor - Place On Cardiac Monitor; Complete Time: 21:46      cw37  
 05/07  
 21:30 Order name: Monitor - Place On Pulse Ox; Complete Time: 21:46      cw37  
 05/07  
 21:30 Order name: Notify Physician if SBP<90 or MAP<65 after the 30 mL/kg      cw37  
 fluid bolus is complete, to obtain Norepinephrine (SEPSIS Levophed)  
 orderr; Complete Time: 21:54  
 05/07  
 21:30 Order name: Notify Physician of vital signs after fluid bolus, for      cw37  
 completion of the Sepsis Reassessment Exam; Complete Time: 21:54  
 05/07  
 21:30 Order name: Saline Lock; Complete Time: 21:50      cw37  
 05/07  
 21:30 Order name: Saline Lock - Large Bore x2; Complete Time: 21:54      cw37  
 05/07

**Moore, Jewellean**

Enterprise Patient ID: 1295838  
 Medical Record #: 368719 / Account #: 61922134  
 ED Physician Notes